



TRICARE SUPPLEMENT INSURANCE PLAN ENROLLMENT FORM

MEMBERS AGES 64 AND YOUNGER

Group Policyholder: Military Officers Association of America
Policy Number: AGP-5889

1. Member Information:

Member Name: _____ Rank: _____
 Street: _____ City: _____ State: _____ Zip Code: _____
 MOAA Membership Number: _____ Gender: Male Female Member Social Security Number: _____
 Member Date of Birth: _____ Email Address: _____ Preferred Phone #: _____
 Initial Service Entry Date: _____

2. Spouse Information:

Is Spouse coverage desired? Yes No Spouse Gender: Male Female
 Spouse Full Name (if enrolling): _____ Spouse Date of Birth: _____

3.

Are you a Member of the Association? A Spouse of a Member of the Association?
 Check the box below if you and/or your Spouse are:
 Retired Military Active Duty Member Retired Military Spouse/Surviving Spouse
 National Guard or Reserve Member Retired Reservist Retired Reservist Spouse/Surviving Spouse
 Medicare beneficiaries are not eligible to enroll.

4. Dependent Child(ren) Information (if enrolling):

If more than 4 child(ren), attach additional sheet.

Child Name	Date of Birth	Student	TRICARE Young Adult
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

Note: Dependent Children must be under age 21 (23 if a full-time student or 26 if enrolled in TRICARE Young Adult); please include proof of enrollment in TRICARE Young Adult with your Enrollment Form. Additional children may be listed on separate paper and attached to/submitted with this form.

5. Coverage Information:

Please select the TRICARE Supplement you want. Choose a plan for everyone you want to cover. Note: Your TRICARE Supplement Selection must match your TRICARE Health Plan. (NOTE: You're classified as a "nonsmoker" if you haven't smoked a cigarette, cigars, or used a pipe or chewing tobacco, nicotine product or snuff within the past 12 months prior to enrollment.) (For administrator use: 04079 if Initial Service Entry Date is prior to 1/1/2018, otherwise 04089. All TRICARE Young Adult coverage will be 04089.)

IN and OUTPATIENT PLANS For TRICARE Select

RETIRED WITH \$400 PER PERSON DEDUCTIBLE	RETIRED WITH \$250 PER PERSON DEDUCTIBLE	ACTIVE DUTY WITH NO DEDUCTIBLE
Member <input type="checkbox"/> Nonsmoker (CL41) <input type="checkbox"/> Smoker (CS41)	<input type="checkbox"/> Nonsmoker (CL21) <input type="checkbox"/> Smoker (CS21)	N/A
Spouse <input type="checkbox"/> Nonsmoker (CL45) <input type="checkbox"/> Smoker (CS45)	<input type="checkbox"/> Nonsmoker (CL25) <input type="checkbox"/> Smoker (CS25)	<input type="checkbox"/> Nonsmoker (AIT5) <input type="checkbox"/> Smoker (AIS5)
Child(ren) <input type="checkbox"/> Under age 21 (CL47) (23 if a full-time student) <input type="checkbox"/> Age 21-25 (04089-CC47) (if enrolled in TRICARE Young Adult)	<input type="checkbox"/> Under age 21 (CL27) (23 if a full-time student) <input type="checkbox"/> Age 21-25 (04089-CC27) (if enrolled in TRICARE Young Adult)	<input type="checkbox"/> Under age 21 (AIT7) (23 if a full-time student) <input type="checkbox"/> Age 21-25 (04089-ACT7) (if enrolled in TRICARE Young Adult)

RETIRED WITH \$300 PER PERSON DEDUCTIBLE	RETIRED WITH \$150 PER PERSON DEDUCTIBLE
Member <input type="checkbox"/> Nonsmoker (CL31) <input type="checkbox"/> Smoker (CS31)	<input type="checkbox"/> Nonsmoker (CL11) <input type="checkbox"/> Smoker (CS11)
Spouse <input type="checkbox"/> Nonsmoker (CL35) <input type="checkbox"/> Smoker (CS35)	<input type="checkbox"/> Nonsmoker (CL15) <input type="checkbox"/> Smoker (CS15)
Child(ren) <input type="checkbox"/> Under age 21 (CL37) (23 if a full-time student) <input type="checkbox"/> Age 21-25 (04089-CC37) (if enrolled in TRICARE Young Adult)	<input type="checkbox"/> Under age 21 (CL17) (23 if a full-time student) <input type="checkbox"/> Age 21-25 (04089-CC17) (if enrolled in TRICARE Young Adult)

INPATIENT ONLY PLANS For TRICARE Select

RETIRED WITH NO DEDUCTIBLE	RETIRED WITH \$200 PER PERSON DEDUCTIBLE
Member <input type="checkbox"/> Nonsmoker (CHN1) <input type="checkbox"/> Smoker (CNS1)	<input type="checkbox"/> Nonsmoker (CLN1) <input type="checkbox"/> Smoker (CLS1)
Spouse <input type="checkbox"/> Nonsmoker (CHN5) <input type="checkbox"/> Smoker (CNS5)	<input type="checkbox"/> Nonsmoker (CLN5) <input type="checkbox"/> Smoker (CLS5)
Child(ren) <input type="checkbox"/> Under age 21 (CHN7) (23 if a full-time student) <input type="checkbox"/> Age 21-25 (04089-CCH7) (if enrolled in TRICARE Young Adult)	<input type="checkbox"/> Under age 21 (CLN7) (23 if a full-time student) <input type="checkbox"/> Age 21-25 (04089-CCL7) (if enrolled in TRICARE Young Adult)

TRICARE PRIME PLAN

RETIRED PLAN	
Member <input type="checkbox"/> Nonsmoker (PHT1) <input type="checkbox"/> Smoker (PTS1)	If enrolling in the TRICARE Prime Supplement (or USFHP), please tell us the date your TRICARE Prime (or USFHP) protection started. <input type="text"/> / <input type="text"/> / <input type="text"/> mo day yr
Spouse <input type="checkbox"/> Nonsmoker (PHT5) <input type="checkbox"/> Smoker (PTS5)	
Child(ren) <input type="checkbox"/> Under age 21 (PHT7) (23 if a full-time student) <input type="checkbox"/> Age 21-25 (04089-PCT7) (if enrolled in TRICARE Young Adult)	

6. Please answer questions (even if only requesting child coverage), read, sign and date.

	Member	Spouse
A. Have you, or anyone enrolling for coverage, smoked cigarettes, cigars, or used a pipe, chewing tobacco, nicotine product or snuff within the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Are you enrolling within 30 days of the date your employer health insurance ends because you are no longer an eligible participant in the program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Are you enrolling within 60 days of termination of Active Duty service or within 30 days of initial eligibility for TRICARE benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Are you enrolling within 30 days of Active Duty service and has your family been insured under the TRICARE Active Duty Supplement prior to your retirement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Are you changing from our TRICARE Prime Supplement to our TRICARE Select Supplement on your Prime Anniversary Date or because you have moved outside of the Prime Network?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. Are you changing from our TRICARE Select Supplement to our TRICARE Select Prime Supplement on your Select Anniversary Date?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Authorization - Please read, sign and date:

I acknowledge that I have been given the opportunity to enroll in the TRICARE Supplement Insurance Plan and that I am age 64 or younger, unless ineligible for Medicare, an MOAA Member and that the above information is true and complete to the best of my knowledge.

I understand that this program may not cover pre-existing conditions (conditions for which I received medical advice or treatment within 6 months prior to the effective date of coverage or until the coverage has been in effect for 6 months). This pre-existing condition limitation will not apply if waived in accordance with policy provisions.

I understand that my coverage will become effective on the first day of the month following receipt of my completed Enrollment Form and payment of my initial premium.

I understand that eligibility to receive benefits under the TRICARE Retiree Supplement is dependent on my (or my deceased spouse's) entitlement to uniformed services retired pay.

I understand and agree that insurance will go into effect upon receipt of my first premium payment and this Enrollment Form and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to MOAA can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance.

Member Signature: _____ **Date:** _____

Spouse Signature (if enrolling): _____ **Date:** _____

8. Payment Options:

Option 1. Electronic Funds Transfer – Select Frequency: Monthly Quarterly Semiannually Annually

Routing Number: _____ Account Number: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If your dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____ **Date:** _____

Option 2. Direct Bill – Select Frequency: Quarterly Semiannually Annually

9. Fraud Notice(s):

For Residents of Florida:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of Kentucky:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For Residents of Louisiana:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Maryland:

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New Jersey:

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For Residents of New York:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Residents of Ohio:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For Residents of Tennessee:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For Residents of Virginia:

Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or who files a claim containing a false or deceptive statement may have violated state law.

For Residents of Washington:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

Mail your completed Enrollment Form to: **MOAA Insurance Plans** • P.O. Box 14536 • Des Moines, IA 50306
Call: 1-800-247-2192 with Questions or to Enroll over the Phone. **Email:** moaa.service@getamba.com

Wellness Discounts



You automatically be enrolled in Wellness Discounts when activating your MEDIPLUS TRICARE Supplement Insurance coverage.

The Wellness Discounts are not available in Utah, Vermont or Washington.

Return this page with your Enrollment Form

For administrative purposes Only:

Member Only (WR01)

Spouse Only (WR05)

Member & Child (WR04)

Spouse & Child (WR06)

Member & Spouse (WR02)

Family (WR03)